MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION

DEPARTMENT OF INSURANCE PUBLIC HEARING

Harry S. Truman Building, Room 492
Jefferson City, Missouri
July 11, 2003

BEFORE:
Scott B. Lakin, Director
Kevin Jones, Assistant Director
Susan Schulte, Property and Casualty Section Chief
Mark Doerner, Property and Casualty Section Senior Counsel

REPORTED BY:

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MR. LAKIN: I wanted to welcome everyone here today and I'm thankful for the big crowd and the interest involved. I think it's going to be an interesting day and I'm appreciative of those that are attending.

I want to welcome you to this special public hearing on whether medical malpractice insurance is reasonably available in Missouri, and if not, whether the Department of Insurance should establish a state-sponsored insurance program known as a Joint Underwriting Association to sell that coverage.

In my February report to Governor Holden, the Department of Insurance suggested establishment of a JUA should be considered as an option -- it should be an option to issue. And the JUA, the Joint Underwriting Association, would be an option to issue policies for physicians in critical specialities that have had extreme difficulty in obtaining coverage or were facing extremely high rate increases in the private market.

We also asked the General Assembly to eliminate legal obstacles to establishing a limited scope short-term JUA until Missouri's capacity problems are resolved by expansion of private insurers.

During the last five months, much has changed as this administration has explored and sought to provide legitimate avenues of relief for physicians who have been

hard pressed to find or afford coverage after several insurers withdrew from the national market or became insolvent in other states.

And over the past year, the Department of Insurance has been very proactive on a number of fronts. We have been expediting the licensing of new qualified carriers, both as regularly admitted insurers and mutuals organized under Chapter 383.

Since January 1 of this year, Missouri has admitted seven new carriers to write coverage for physicians and surgeons. This is an extraordinary influx of insurers into this market.

Today at least nine companies are accepting applicants for new coverage up from five in January. And we have made access to those insurers easier by publishing a web directory on the MDI website of those insurers and their contact information.

Expansion of this market and whether the field of competitors provides adequate options for healthcare providers will play a primary role in whether I determine medical malpractice coverage is reasonably available and whether a JUA is warranted.

The Department has also quickly and forcefully moved to prevent unlicensed insurers from scamming Missouri doctors who are searching for cheaper coverage. In the past

month, MDI has issued a Cease and Desist Order against one illegal operation and gone to court to block another unlicensed Caribbean carrier even though it had the veneer of respectability and endorsement of major medical groups in the state. And these groups were misled about their legitimacy, in my opinion. In a minor miracle, the Caribbean plan may have been halted before a single doctor bought a policy, although some submitted formal applications.

By early fall MDI will complete an unprecedented financial and market conduct examination of the medical malpractice insurers in Missouri that would provide further insights and will provide further insights into how our problems developed and how they can be solved and prevented hopefully in the future.

I have invited a consulting actuary who is assisting on that project to testify today and make comments on facets of the Missouri market that are tied to establishing a JUA.

We also have good news on the payment front. Most of the physicians' consternation about medical malpractice rates involves the crunch they encounter between rising costs and flat or declining income, particularly because they've signed insurance network contracts with steep discounts. Physicians have continued to complain that

HMOs and other insurers, despite those discounts, still fail to pay on a timely basis.

In 2001, the legislature responded to those concerns by enacting a new prompt pay law in Missouri that took effect in January 2002. And last fall we began a series of exams at the Department of Insurance to determine whether these insurers were complying with those standards.

This month the first HMO found to be in violation paid a fine of more than $100,000 and other cases await. These fines will not only deter those companies subject to fines, but serve as a warning to other insurers and HMOs, the State will act unless they pay physicians promptly as required by Missouri law.

Within the next two weeks I expect also that the Governor will announce the appointment of the Blue Ribbon Missouri Commission on Patient Safety, which will make recommendations on how to reduce the rate of medical errors that result in malpractice litigation and prevent these injuries as -- preventing these injuries is by far preferable to any other fix of the medical malpractice system.

I regret to report that the General Assembly did not enact or even hold hearings on our proposals for establishing a JUA. Late in the session the legislative leadership also abandoned similar plans to found a

state-established medical malpractice insurer owned by policyholders like Missouri's Employer Mutual Insurance Company, which was set up to expand capacity for Workers' Compensation in 1995 and is now the state's largest such insurer.

After the Governor in March wrote every doctor about the kinds of medical malpractice changes he would sign, the legislature only passed a bill tainted by non-medical special interest provisions that are injurious to all Missourians. And Governor Holden, as many of you know, vetoed that bill on Wednesday.

And so at the Governor's request, I am holding this hearing today to see whether the administration should take another step toward helping physicians and other healthcare providers by establishing a JUA. We are particularly interested in hearing testimony about how new insurers have affected the market both on price and availability during the recent June renewal cycle.

And I have asked Mark Doerner of the Missouri Department of Insurance, our property and casualty counsel, to begin today's hearing by providing an overview of the current statute authorizing the Department of Insurance to establish a JUA.

And those are my opening comments. I'd like Mark to come up and we'll proceed with the hearing. Thank

you.

MR. DOERNER: Thank you, Director Lakin. As he said, my name's Mark Doerner. I work with the Missouri Department of Insurance, P&C section.

I'm just going to give a basic run-through of the statute in question that we're working with, which can be found in several sections starting at Section 383.150 and running to Section 383.195 of the Revised Statutes. These provisions were part of a bill, House Bill 1309, that was passed back in 1976 and so far as I can tell, haven't been amended since then.

Even though these provisions on a JUA are contained in Chapter 383 of the statutes, I want to just make a brief comment that we should distinguish between a JUA and what we typically call, at least in the department, a 383 company.

That chapter has a couple different areas of law that it deals with, and one is the creation of these so-called 383 companies which are assessment entities that are designed to provide coverage to professions like physicians who set them up.

The 383's have a different set of regulatory guidelines that they follow compared to other insurance companies. The 383 companies were authorized as an alternative to the normal insurance market.

When we're talking about a JUA, however, we're not talking about a 383 company in that context. What is a JUA? It's basically a mechanism for combining the resources of several insurance companies in order to underwrite a particular type of risk.

We have these Joint Underwriting Associations in a couple different areas in the state right now for auto insurance, for fire insurance, for people who can't find homeowners coverage. And then we also have a similar entity for Workers' Compensation.

They function as markets of last resort for people who need or desire coverage but cannot find it through ordinary methods. And what the JUA does is have a mechanism that makes that coverage available and then provides the underwriting, the insurance for that product.

In this case, what the statute says is that the members of the casualty insurance industry are all going to be members of a JUA if the Director of Insurance decides to establish the entity. And what they are going to do is essentially provide a level of insurance to pay for losses if the premiums that are charged for the coverage prove to be inadequate. So they're essentially there to pick up a deficit if one occurs.

I want to distinguish between a JUA and a competitive state fund, because some of the comments that

I've seen on our e-mail system seem like they might be confusing the two.

The Director mentioned Missouri Employers Mutual, which was an entity that was set up for Workers' Compensation back in 1994 and was established as a competitive state fund. Essentially the state set up a new insurance company to provide competition to the rest of the regular insurance market.

The JUA concept is a little bit different because it's really not designed to set up a competitor, but rather to provide market of last resort.

And I guess there are a couple things that distinguish the two. You don't have -- in the instance of a JUA, typically what you have is a board of directors that is made up of the insurance industry that is going to be assessed in case of a deficit. And that's what we're talking about here.

In addition, you typically don't see the JUA's getting very large in terms of the amount of premium they take in. For example, the FAIR plan that provides fire insurance writes, at least based on my quick calculation, about 1 percent of the premium that's available in that market. The Workers' Compensation pool that we have established has -- in 1999 it was writing only 1.7 percent of the premium. It's up to 5 percent in 2002.

By contract, when you have a competitive state fund like Missouri Employers Mutual, that entity is operating at a much higher capacity. It was writing 14.7 percent of the market in '99, 21.2 percent in 2002. So it's a much bigger player.

That's not what we're talking about here. We're talking about an entity that's in the single digits, if that, for the amount of coverage that it's writing.

Section 383 talks about the purpose of this entity sort of obliquely, but it says that it's there to provide for economic, fair and non-discriminatory administration and for the prompt and efficient distribution of medical malpractice insurance.

The chapter defines who this is supposed to be available to when it talks about healthcare providers in its definition. The definition seems to me to be pretty comprehensive in terms of people who are generally licensed to provide healthcare in the state of Missouri.

If there's anybody that's left off that definition, it strikes me that that is because this statute was written in 1976 and we've added a couple professions or designations since then.

Section 383.155 covers a couple different key elements. One of them is the creation of the JUA. And like it says behind me, it is supposed to be set up upon the

determination by the Director of Insurance after a public hearing that medical malpractice liability insurance is not reasonably available for healthcare providers in the voluntary market.

And since we don't really have a de-voluntary market for med mal right now, then what we're talking about is presumably both the regular insurance market and the surplus lines market. And so what we have to conclude is that that coverage is not reasonably available from those sources.

As I said, the members of the Joint Underwriting Association are supposed to be those casualty insurance companies who are actively writing on a direct basis as opposed to a re-insurance basis.

Section 383.155 talks about the powers of the JUA and what it's supposed to do is issue medical malpractice insurance policies as it sets some limits. It says the policies can't be larger than $1 million for each claim or $3 million in the aggregate for a single year.

The JUA is also authorized to underwrite those policies, to adjust and pay claims and to assume and seize re-insurance on that coverage, although I'm not quite sure why that's in there.

The statute talks about establishing a plan of operation which covers a number of elements such as setting

up facilities, the management of the JUA, assessments, setting underwriting standards. And it gives the JUA the authority to appoint a servicing company to handle the business.

And then it talks about the timing of that plan of operation, and it's a fairly quick turnaround that's being requested. It says that the board of the JUA is supposed to develop the plan of operation within 45 days following the creation of the JUA.

That plan is supposed to be run by the Director of Insurance. And then after his consultation with the members of the JUA, representatives of the public and other affected individuals or organizations, he's supposed to determine whether or not to approve that plan of operation. If he doesn't, the board has another 15 days to amend the plan. If he still does not approve it, then the Director is given the responsibility of developing the plan of operation.

Section 383.160 talks about the types of coverage that are available and the rates to be charged for that coverage. And basically it's somewhat unique in the current framework because it talks about issuing occurrence policies as opposed to the more typical claims-made policies that we see in the med mal market.

In discussing the rates that are supposed to

be charged for that coverage, basically it's saying that the rates are supposed to be adequate to cover the losses that are incurred. It says that those rates are supposed to be actuarially sound and calculated to be self-supporting.

And then it also goes on to talk about how you come up with those rates. It says that the JUA is supposed to give due consideration to past and prospective loss and expense experience in the medical malpractice insurance market for all insurers. It's supposed to consider trends and frequency and severity, investment income and any other information that the Director may require.

And then it goes on to talk about assessments in case that amount proves to be inadequate. And it says that there's going to be a -- if assessments are required, it puts a cap on how large those assessments can be. And that cap is 1 percent of the net premium casualty premium for the members in a year. And if that is paid, then that amount can be offset against state taxes and that's in Section 383.160.

Another provision that's somewhat problematic is 383.165 that says that in the first year -- the first policy year, that the JUA is supposed to charge, in addition to the first premium, a charge that's equal to that premium to each policyholder. We typically talk about that as the double premium element of the statute internally. And I'm

not sure why that's there when they've also said that the rates are supposed to be actuarially sound.

There are some indications with the language that they're assuming that there's going to be a significant start-up cost associated with this entity, because the statute also talks about the board finding facilities and so forth for the operation. And so perhaps the intent there is to provide the start-up funds for that type of operation.

As far as eligibility of this coverage, it's supposed to be available to any healthcare provider. They're allowed to apply apparently directly to the JUA, although the statute also says that they may apply through an agent or broker.

And then they are allowed to receive coverage if they meet the JUA's underwriting standards, if they have no outstanding premium obligations to other insurance companies and if they pay the premium or portion of the premium that they're required to by the JUA.

In terms of the operation of this, it's supposed to be overseen by a board of directors. The members of the board are set forth in the statute. The board is supposed to be made up of eight members from the following insurance entities: Two are from the American Insurer Association; two from the National Association of Independent Insurers; and two from the entity that's now

called The Alliance of American Insurers; in addition, the final two members are supposed to be from insurance companies, casualty carriers who are not members of any of those three trade organizations. The board is to receive its actual and its necessary expenses, but no reimbursement beyond that.

Then the statute also talks about an annual report that's supposed to be done under a format approved by the director, an annual examination of the association. It says if anybody is aggrieved, say, applicants for coverage or insurers by the JUA's actions, can appeal them to the Director and his decisions can be appealed to the Cole County Circuit Court.

And then finally, it provides for termination of the Joint Underwriting Association should coverage become reasonably available in the market. And that's in Section 383.195.

So if we decide -- if we decide to set up a JUA, we've got a whole host of issues that we're going to have to discuss in terms of how to set this up such as, you know, how to do this -- these underwriting standards. We're going to need to figure out this function of collecting the data from all insurance companies to provide the basis for the rates to be charged. We're going to have to deal with this two-year premium issue.

But the focus for this hearing today is on the two items that are on the board behind me. We need to figure out, first off, whether or not coverage is reasonably available in the voluntary market, and then should we establish a JUA to deal with an availability problem, if it exists.

I would think that in trying to determine what the first item is talking about, it strikes me that it is not simply an issue of mere availability. Because if that had been the case, then they wouldn't have used the term "reasonably" as a qualifier.

It seems to me that they're talking about something in addition to mere availability. And I suppose that we're going to be interested in finding out about how difficult it is to find coverage in the current market, what the cost is and so forth.

And those two questions are the keys to our analysis today. And I apologize if the panel asks questions that try to keep the remaining speakers to focus on those particular issues, but that's where we're headed.

And then, finally, I'd like to state for the record that we have had a number of people who have commented on our website about this issue and the upcoming hearing. I just want to note that we have received those comments and we'll consider them as a part of our

deliberations on this.

We have received comments from a Mr. Stephen R. Baugh or Bough, B-o-u-g-h, Dr. Daniel J. Bauer, Mr. Joe M. Woods from The Alliance, Glen Glasgow, Dr. John A. Hunter, and Rebecca Speake, who I think is going to be talking later today.

That's the end of my overview. Thank you.

MR. LAKIN: I want to, first of all, introduce the panel that are sitting next to me. Kevin Jones, who is my assistant director, is to my right. You just heard from Mark Doerner, who is the property and casualty senior -- I'm sorry -- property and casualty section senior counsel. And then Susan Schulte, who is the property and casualty section chief for the Department of Insurance.

And with that, we'll move on. And I think we are actually three minutes ahead of schedule. But I'll call David Cox to come forward and I will -- I guess you can use the podium if you want or if you want to use the table over there, that would be fine. David is going to talk on the Missouri market conditions.

David, welcome.

MR. COX: Thank you. Can you hear me okay?

Good morning. My name is David Cox. I'm a Fellow of the Casualty Actuarial Society and a member of the American Academy of Actuaries. I also hold a Master of

Science degree in mathematics. I've been -- I have about 25 years of experience in the actuarial -- field of actuarial science.

And I meet the qualifications requirements of the American Academy of Actuaries to provide expert testimony in the area of medical malpractice insurance. I have been retained by the Missouri Department of Insurance to provide actuarial consulting services regarding medical malpractice insurance matters.

My testimony this morning will address three topics. I want to discuss availability issues; and the importance of establishing a JUA; and, finally, I'd like to address some of the issues involving data issues and why we need good statewide data for medical malpractice insurance.

I've conducted analysis of the premiums written in the first quarter of 2003 by the leading med mal writers in Missouri. And this analysis indicates that there is an overall reduction of availability of professional liability insurance for physicians and surgeons in Missouri.

Since 1999, several major insurers have quit the Missouri medical malpractice insurance market. These include PHICO, Saint Paul, Chicago Insurance Company, and the Reciprocal Insurance -- Reciprocal of America insurance companies. And another major insurer has curtailed writings in Missouri.

I provided you a handout, and in the back the very last page there's an exhibit of my analysis. And these are the top five writers in the state: Intermed, Medical Assurance, Chicago, Medical Protective and the Doctors Company.

And in the first column it shows the writings -- the premiums written for all of 2002 for the physicians and surgeons category. These five companies total about $90 million or about 80 percent of the market.

The data that we have on a quarterly basis is shown in Column 2 and 3. I've tabulated the direct written premiums for these companies for the first quarter of 2002 and the first quarter of 2003.

Now, the data available by quarter isn't by type of insurance. It's also coverages combined. But for these five insurers, they primarily write physicians and surgeons. To a very high degree, that's the business that they write.

In the fourth column I show the rate changes that had taken place for each of these companies during the -- between the first quarter of 2002 and the first quarter of 2003.

The overall premium for the first quarter of 2003 only increased about 4 percent for the year. It increased from the first quarter of 2002 from 22.7 million

to the first quarter of 2003 of 23.5 million. That's only a 4 percent increase. And at the same time there were substantial rate increases going on.

So I have differentiated between the growth rates due to rate increases and the growth rates due to exposure -- changes in exposure. And within the companies there's some very large changes going on.

Chicago Insurance Company's writings have gone down dramatically and Intermed's writings have gone down slightly, but they -- but they've also had substantial rate increases during that same time.

The important thing -- the way to measure the change in availability is the sixth column, which is the estimated exposure growth. And in total I'm estimating that the change in writings, other than due to rate increases, is down 11 percent for the quarter. And this indicates that availability has been reduced for these carriers.

This result supports the contention that availability of medical malpractice insurance is reduced in Missouri.

The size of the reduction is also significant considering the importance of medical malpractice insurance. This is an overall change and within that change there will be special-- groups of doctors that will be more severely affected than others. Particularly surgeons and

obstetricians would have a much more difficult time providing -- finding insurance.

Now I'd like to address the importance of the JUA. Missouri has suffered reduced availability in recent times. And a JUA would provide an important and beneficial insurer for the medical community.

As Mark already pointed out, other important segments already have a JUA. And these JUAs have served the other segments during episodes of curtailed availability. And they've -- we keep these plans around for that very purpose. And this same purpose could be achieved for medical malpractice.

It would provide a stable source of medical malpractice insurance when -- during those times when the commercial insurance market is either unwilling or unable to provide the coverage.

The stability of the medical malpractice insurance market is enhanced by a JUA. And it's enhanced by attaching the JUA to a much larger, more stable insurance market. And that's the entire statewide casualty insurance market. So it's borrowing the stability from the entire casualty market to provide additional stability for the medical malpractice market.

The JUA would be beneficial, but it's also not harmful. The statutes provide that the JUA would not be a

burden on the industry in that the assessments, if any, would be offset against premium taxes. And if the JUA proves to be unnecessary, it can be terminated.

I've looked into data issues in Missouri involving medical malpractice. It's very important for decision makers like yourself and for the insurers who have to set rates that they have a good, quality, accurate data, complete data.

Missouri currently has no credible source for statewide rate-making data for medical professional liability insurance. This has made some insurers wary of Missouri and has aggravated the availability problem.

Insurance Service Offices, ISO, is charged with a task of gathering rate-making data, but they have very low membership in Missouri, because their membership in ISO is optional in Missouri. Insurers are not required to be members of ISO and many are not.

And as a result, they collect statewide data, but it's only fractional data. And it's not -- it's not enough data to be used for your -- to be useful for the insurers.

Unlike other lines of insurance, medical malpractice has no dominant, long-standing insurer in Missouri to provide a surrogate benchmark. In automobile insurance, for example, State Farm could be looked at as

providing a big source of benchmark data of what the rates -- of what a reasonable rate would be. We don't have that in Missouri for medical malpractice.

And Missouri data, even if it were available in its entirety, would still be insufficient -- have insufficient volume to address all of the rate-making needs. Insurers do today and will continue to need to rely on broader data from other states for such things as establishing rates for higher limits of liability or for rates for certain medical specialities.

For example, there aren't enough surgeons in the state to set a rate for just surgeons. So you need to look at surgeons countrywide. And that type of state -- countrywide data will always be needed.

The lack of statewide data doesn't stop insurers from writing insurance. But what it does do is it increases the risk of pricing errors. Either they set the rates too low or they set the rates too high. And also the lack of data may discourage market participation.

So the data is -- the data problem is something that can be dealt with. It's not something that is unattainable. It's a matter of getting -- collecting the data and actually going and getting it. And it would be beneficial to the decision makers and particularly beneficial to the insurers and the policyholders so that

they don't have -- we don't have extreme pricing errors.

The JUA could possibly fill this data void by collecting rate-making experience from Missouri malpractice writers as alluded to in the statute. The statute seems to make that option available. This statewide data would enhance the accuracy of the JUA rates and it would also benefit the policyholders and the insurers by reducing pricing errors.

And that concludes my testimony. Do you have questions?

MR. LAKIN: David, thank you.

Are there any questions of David from the panel?

Thank you. Interesting. They're letting you off easy.

All right. Next is Tim Trout and Don Carmody, Missouri Physicians Mutual.

MR. TROUT: Director, thank you for having us today.

MR. LAKIN: Welcome.

MR. TROUT: I'd like to introduce myself. My name is Timothy H. Trout. By way of background, I have 25 years experience in selling and managing and developing strategic positions for professional liability insurance companies as well as working with individual physicians in

the state.

In the last year, I've started an operation to bring forth and bring back to the state stability to physician professional liability insurance by forming a new 383 in the state. This company is called Missouri Physicians Mutual. We were granted authority in late February of this year.

If we look back on the history of the state when there was stability, affordability in the state, we had two mutually assessable companies, Risk Control Associates and Medical Defense Associates. And we had a situation where physicians benefited from a very stable market because the majority of the physicians in the state were insured by the companies which they owned. Missouri no longer has but -- well, I guess there's three now companies that are 383's.

A 383 provides that the insureds own the company, therefore, they can certainly help direct and stabilize the marketplace. My job as the managing director of Missouri Physicians Mutual, is to be proactive, not reactive, and figure out ways to help physicians break the professional liability insurance.

And I must tell you that I respectfully disagree with our previous speaker with regards to the competition in the marketplace. Missouri is a file and use

state. And I have found time and time again what's on file and what is used are two different things.

We have since the beginning of March been very successful in our underwriting. We have written close to $6 million collective premium and have some $14 million in premium out on quote.

The idea of the state looking at this from a long-term perspective as well as a short-term, if we look around the country and see which states do have stability for their physicians, it's because they have one predominant carrier that is owned by the physicians. If we can achieve this in this state, I firmly believe that we will again have stability in the rates as well as the availability.

In the 300 and -- well, almost 400 applications that I have reviewed in the last three months, there has been but two that I have not been able to work out some sort of a premium for short of a premium that would equal the policy limits. And that was for physicians that had claims and claim histories that were so egregious that perhaps it's not an insurance industry problem, but a medical professional problem.

I recently returned from a meeting in Florida looking at the underwriting standards and new ways to underwrite to be fair to physicians. And it became abundantly clear that the 80/20 rule we see in a lot of

industries is very much in keeping with the physicians' professional liability, that 20 percent of the physicians in the state are causing 80 percent of the losses. To break it down even further, about 4 percent are probably causing about 30 percent of the losses.

The idea of providing good healthcare in the state of Missouri, which I do believe the vast majority of physicians wish to do, I think if the Division or the Governor or the legislature, I don't know who would do this, but if they would grant immunity to hospital review boards and perhaps even take the physicians off the review boards so that those physicians that are incompetent or should not be practicing medicine in this state can be removed and the review boards are not subject to lawsuits or personal liability, we would see a tremendous increase in quality of care for the consumer and we'd see a tremendous decrease in the amount of claims brought forth in this state, which would then again result in a precipitous drop in premiums.

At the end of the day, it has to be clearly understood by the medical community in order to bring stability back, we have to change the way professional liability has been handled in the past. It cannot be business as usual.

Professional liability in the past has allowed physicians a consent-to-settle clause where it is up to the

physician to make that decision as to whether a claim is resolved in or out of court. In many cases physicians are either unwilling, unable or too stubborn to admit that perhaps they made a mistake and drag these cases out over years, costing insurance companies untold thousands of dollars.

The insurance companies themselves are equally egregious in their inability in the past to pare down and cut their costs. The insurance companies typically have just passed their cost through to physicians and that too has to change, particularly in physician professional liability insurance.

And, thirdly, when physician professional liability insurance carriers retain counsel to defend them, there has to be some sort of a capitated review board for this. The single largest cost in physician professional liability is defense coverage, is defense cost, which tells me that it's not -- the system's out of whack. We need to have those dollars there to pay injured parties, not defense attorneys.

We are looking forward to and have enjoyed a very, very well-received business plan. We have put together a company with fixed pricing for all of our out-sourced business.

That's the reason Mr. Carmody is here. He's

our general counsel as well as our gate keeper for the defense of our physicians, our insured physicians across the state. It will be his job to monitor, keep track and make certain that we, in fact, bring legitimate claims to quick and quiet resolutions.

All in all, I think if a JUA carrier came in the state and wrote on an occurrence form basis, it would create even a larger cost to those physicians who are now complaining of higher premiums because they would then have to buy their tail coverage from someone in the marketplace, which is typically two to three times of their current premiums. And then to suggest that they'd have to pay two times an occurrence form premium that is actuarially sound is not a real resolution.

The real resolutions are what I have mentioned. We have to have a company that is willing to run not for profit. We have to have a company that will share its data with the state at all times, a company that will keep its cost in line, keep its costs so that, as our business model shows, where we can put at least 60 cents of every dollar into the claims pool as opposed to the majority of the carriers in the state that are putting about 20 cents of every dollar they collect into the claims pool.

MR. LAKIN: Tim, let me interrupt you there because we've got to keep it moving.

MR. TROUT: I understand.

MR. LAKIN: It seems like every decade or so we have this cycle that comes through that we have the medical malpractice crisis. And we've had 383's in the past and they sort of come and go depending on what the private market's doing.

And I guess what I would ask is, how does your 383 differ from those that have been tried in the past? Because you say that, you know, your 383's the way to go and that the JUA is not necessary. But what I'm saying is -- and we heard testimony from the actuary about stability of the marketplace.

And so I'm curious as to how would a 383 and the current one that you all are involved in, how does that differ from some of the 383's that have been tried in the past? And if, you know, we get through the cycle and the private market comes back, you know, will you still be there or will you be --

MR. TROUT: I think the honest answer to that is the difference is -- and I mean this not to be indifferent to physicians, but our company is not run and operated by physicians as the two previous 383's have.

The two previous 383's that were operated in Missouri were physician board, physician-run companies who had an opportunity to convert their companies to stock

companies and shortly thereafter they, in fact, sold them out to out-of-state interests. The one stock company in Missouri, Missouri -- or MOMEDICO did the same thing. They were not a 383, but, in fact, a stock company and they sold out to an out-of-state interest. Missouri had no Missouri physician-owned company, and once that occurred, that's when this market came out of whack.

Our promise is we will not convert to a stock company and sell the physicians' carrier out. That's one of the major differences.

Your other question, I'm sorry I forgot, Director.

MR. LAKIN: I'm sure there's people here that probably didn't.

Basically my question was how your 383 will differ. And then I talked about why -- based on the actuary's testimony, why a JUA wouldn't be a stabilizer of a market and maybe even benefit your 383.

MR. TROUT: Well, a 383 in itself is a stabilizer, in my opinion. A 383 is really nothing more than a loss retro insurance program. You take a deposit, you base that deposit on actuarially sound premiums and collect premiums over a period of years.

And if, in fact, you did not collect enough, you have an assessment to the insureds. You collect the

assessment and you go forward again on another loss retro program. If you've collected too many dollars in premiums, you lower your premiums.

MR. LAKIN: Do you think that a JUA would not set their premiums to be in line so that they wouldn't have to assess the companies involved so that -- and then the companies turn around and take a deduction on their premium tax, which hurts general revenue so we don't want to do that. So do you think that the JUA would not set their premiums correctly for the market?

MR. TROUT: Well, if the JUA set their premiums correctly for the market, then there would be no reason to have a JUA because there is tremendous capacity out there right now. There are a substantial amount of carriers that are ready, willing and able to write physicians at actuarially sound rates. The problem is there are some physicians that, unfortunately, have had a history that makes them almost uninsurable. It's a very clear pattern that's been developed.

We have had and insured some physicians based upon excluding some procedures they've been doing in the past. We've taken very proactive approaches to them. We've had some that we have had anger management brought forth to them and said, We will give you an additional 10 percent credit once you've completed some sort of a course.

It is statistically proven that personality profiling in physician professional liability insurance correlates directly to the amount of losses these physicians are going to have. And as such, we're going to insist upon profiling our insureds so that we can help all physicians in the state become better physicians and --

MR. LAKIN: So you said you had two that you didn't write, but other than that, you've basically taken all comers. Because you're really doing it on a conditional basis, aren't you? I mean, you're excluding procedures, you're telling them, We'll write you for the coverage, but not unless you agree not to perform X, Y and Z procedures; is that right?

MR. TROUT: Yes. What we have -- and I'll give you a classic example was an obstetrician that has had 20 years of unremarkable service in the sense that this particular physician has never had a hint of any lawsuit for prenatal care, vaginal and C-section deliveries.

But every time this physician put a laparoscopic gun in her hand, this physician was sued. I mean, it became abundantly clear that this physician was not qualified for that procedure. We told the physician that we would gladly insure this physician with exclusion of that procedure.

MR. LAKIN: It just seems to me that you're --

you know, the differences between a 383 and a JUA are -- or the difference is basically you're taking in the premiums and if you don't have enough to pay the claims, you assess the small group of doctors that you're insuring. And if a Joint Underwriting Association takes in premium and they don't have enough money to pay the claims, they're spreading the risk over a lot bigger group of property and casualty writers.

MR. TROUT: Precisely. And if this would occur, why would a physician buy insurance from Missouri Physicians Mutual with the possibility of an assessment as opposed to the State's program where they know that there's no assessability to it?

MR. JONES: I was just going to say, just to build on your question, Director, I mean -- make sure I'm understanding what you're saying. If we're to add a JUA to the options available to providers in the marketplace, you think that that would have a negative impact on your business and other carriers' business?

MR. TROUT: I do if you take on all comers and I do if you do not charge actuarially sound rates.

MR. JONES: Now, you heard Mr. Doerner talk about how the law says that we have to set -- we have to charge actuarial sound rates in a JUA.

MR. TROUT: I heard that. But I also heard

that -- and I've not heard, I guess, that it will be limited to physicians who allege they can buy coverage nowhere else. Because there is capacity -- I've yet to see a physician through the brokerage firm we're representing that has not been able to get a quotation.

MR. JONES: So you're providing quotes to everybody that comes?

MR. TROUT: I said we've turned down two. We've turned down --

MR. JONES: So you wouldn't even provide them a quote; is that --

MR. TROUT: No.

MR. JONES: Okay.

MR. TROUT: We look at the Weiss report that was published earlier this year, their conclusions and my conclusions and that of many people are very similar.

And this is not just an issue of insurance companies, because I think insurance companies have been outrageous in their behavior and that's why I personally took it upon myself to start this company up. But the medical profession itself has to assume some of this problem themselves by policing themselves better. Thank you.

MR. LAKIN: Any other questions?

Thank you.

Don, do you want to save --

MR. CARMODY: Mr. Director, just first of all, I'd like to introduce myself, Don Carmody again, counsel for the company. And I'd like to thank you for the opportunity to be here, for both of us to be here.

When I originally became interested in this particular hearing today, I looked at the 383 statute. Counsel has already made a complete analysis of it. But our concern, as a company, has simply been if the JUA is something the State wants to do, a major concern of ours would be the scope. And I think your question hit on that particularly.

In other words, if the 383 has a possibility -- a possibility, although remote, of assessment, the JUA does not have such a possibility because, in effect, the casualty companies will pick it up and ultimately they'll get a tax break, they won't have to pay that amount in taxes.

So, in other words, at the end of the day, it appears that any shortfall upon the premium will actually be subsidized by the State. We think the effect of that is that it will do two things. Number one, it will certainly eliminate any competition coming into the state, any other carriers coming in because they're not going to be able to compete either. They can actually have losses.

And the same for the existing carriers. We

think that the existing carriers will be affected. And we have to tell you that it would be a situation where we would be actually at the end of the day in a very precarious business position. So for us, the scope is of great concern.

I think that Tim has already told you that the nature of his business and how many people he writes and the reason he writes them, the number of quotes he has. And I know Mr. Cox has made his study, but unfortunately, his study, from what I'm gathering, stopped in March and that was just before we began doing, you know, active business in the state.

But I do want to tell you that I did have a chance to read your analysis that you prepared in January of 2003. And in your analysis you said, among other things, that the statute is not workable in today's environment for a number of reasons, the double charge which counsel mentioned, and the structure would impose a substantial cost on the general revenue fund; and, finally, there would be a question arguably about the scope.

The statute hasn't changed. It's the same. And we think the General Assembly, if there's going to be involvement of a JUA -- you know, for you in order to maintain the competitive marketplace and the voluntary market that all -- you want to have here, I think the

scope's going to have to be limited so that they're not going to be in active competition as a common carrier in the state.

MR. LAKIN: I would agree that it depends on how it's set up. And, you know, I think you've got to be real clear that -- and I've worked on this, you know, for the past year pretty -- pretty extensively, but there is no silver bullet in this as far as how we make things, you know, perfect in the state of Missouri.

But I do think if it's set up correctly, that the JUA has some possibilities to -- as the actuary noted, to stabilize some markets. But I understand your concerns from someone just starting up and starting up a 383 on what effect it will have on your business as well.

Mark?

MR. DOERNER: Yeah. I was just going to ask what you would think about the notion of -- if we set up a JUA, of having any application first be essentially shopped out to the existing writers in the market. You know, somebody comes in the door they say they can't get coverage elsewhere, you guys interested in writing them so you can look at that beforehand, does your concern go away?

MR. TROUT: That's interesting you say that. We discussed that on the way down as something we would certainly ask that you would do is, at the very least, a

physician would come in and show you at least three to four letters of rejection by other active underwriting carriers in the state. But your way would be a better way.

MR. CARMODY: Your way would be the way to do it. And then, in other words, you would be the -- an insurer that the last -- what the whole concept is in a way.

MR. LAKIN: Okay. Thank you, gentlemen.

MR. TROUT: Thank you very much for your time.

MR. LAKIN: Next up is Mike Delaney of the Missouri Hospital Plan and Healthcare Services Group. Mike? After Mike, Bill Spencer with Podiatry Insurance Company of America is scheduled and, Bill, if you can come on down now, we'll try to speed some of this up. Mike?

MR. DELANEY: Thank you. I'll try to throw my two cents in quickly. I hope it's worth a little bit more than that.

I'm Mike Delaney. I manage the Healthcare Services Group Companies that include the Missouri Hospital Plan and its subsidiary stock company, Medical Liability Alliance.

MHP is a 383 company that has been continuously active in the state of Missouri insuring hospitals since the last crisis of 1985. We were formed in 1986 actually and began writing policies January 1st, 1987. We insure primarily not-for-profit small community hospitals

and their medical staffs.

And, quite frankly, when I read your report last February, Mr. Lakin, I agreed that there was some validity to the prospect of a JUA for the critical specialities, but I do not think it should be -- and I don't know how you would go about setting preference, but I don't think it should be available to all physicians in the state.

And I don't think it's necessary for all the physicians in the state, because we do have people like Missouri Physicians Mutual now writing business.

We do not necessarily have an availability crisis. What we have is a price crisis. And the price crisis is affecting physicians to the extent that they're considering moving out of the state, moving to Kansas or -- or moving to other locations because they do not care to pay, in some cases, the cost of the available insurance.

I believe that if this is a crisis, it's, like I said, one of affordability. And I believe the critical specialities, which you defined I believe in your report or in your letter with your report, are the hardest hit because they deal with the most severe cases and ultimately can be targeted for the larger plaintiff verdicts. And --

MR. LAKIN: Mike, if it's not affordable, is it available? I guess -- I mean, I went through this when I -- in my debate on healthcare insurance, you know. If

it's not affordable, is it really available?

MR. DELANEY: I think it's available. I think Mr. Trout made that clear that it's available. And I'll give you an example. Just last week one of my small rural hospital administrators called me. He's got a 29-bed hospital. He has one OB in town and that OB -- without that OB, people of his community are going to travel over 100 miles to a larger city to have their babies delivered or in their car.

This OB has had 11 claims. And none of which were particularly severe, but my underwriting guidelines suggest that I cannot even quote that OB. We did, through our agency, find a price in the surplus lines market for over $300,000, which is more than the OB makes.

And this administrator was very unhappy with me for not being able to provide the service that I would like to provide. And he said, We went to the Keene Agency and we were able to find coverage for $125,000, which is still a lot of money I think.

And I suspect that it was probably Missouri Physicians Mutual that insured this doctor. I have no problem with that. I want the doctors practicing at my hospitals to have insurance. I think that's beneficial to the hospital. Because without insurance and following the Scott decision, my hospital becomes arguably responsible for

their actions.

What's more, I think the Scott decision is still hanging out there and we are going to have a problem until it's fixed.

MR. LAKIN: So you're saying that the problem really isn't availability of medical malpractice insurance, but the doctors trying to figure out how they're going to finance it basically?

MR. DELANEY: I would agree with that. I would also suggest to you that this is the third time that the commercial carriers have bailed out of Missouri when things got bad. I don't think many of them are coming back.

And so we're going to need other solutions such as a physicians' 383. And I hope that they are very successful, because I think it's important that we insure our physicians.

I also think that it's a good idea for the State to engage the problem. That's exactly what they did when they created the legislation that allows companies like mine and Mr. Trout's to exist. I think that a JUA is an example of the State engaging the problem.

And I, quite frankly, can't tell you whether or not it's the best solution, but you have to begin coming up with potential solutions before you can settle on the best one.

MR. LAKIN: You think the JUA is just another option that physicians can have --

MR. DELANEY: The JUA --

MR. LAKIN: -- along with 383's?

MR. DELANEY: -- it has to be the market of last resort. I -- if you look --

MR. LAKIN: We've got examples in other fields as has been noted by Mark and David that, you know, other types of insurance have a JUA type option.

MR. DELANEY: Insurance people like to talk about critical mass, makes us sound like we're nuclear scientists. We don't have critical mass in -- with the number of physicians that we insure in the state overall.

The global population is somewhere around I think 15,000 licensed practicing physicians. Even if you insured all of them, you would still be -- and I defer to the actuary. You would still -- you would still have a hard time coming up with the kind of sound pricing that you get in homeowners policies or automobile policies.

But your JUA is there. Haven't driven the commercial market out of Missouri. They help the commercial market. And a JUA, because it is a voluntary approach to the solution, can be there when the market gets hard and it will be there when it's soft, but the policyholders will go elsewhere. It's just there as a backstop. And you only use

it when you need it.

MR. LAKIN: So are you saying you're in favor of JUAs just on a limited basis or you just don't want too much of the JUA?

MR. DELANEY: Well, I don't -- I don't -- I am offering to insure physicians associated with my hospitals, but I don't really want to attack the entire market. So I don't have much of a dog in that fight.

And, quite frankly, I would prefer that the JUA not be necessary, but I also want to see to it that the doctors practicing at my hospitals have insurance coverage. The JUAs that are successful ebb and flow with the market. Unlike -- unlike a patient's compensation fund, which I -- I think Mr. Trout would probably argue against also, is that it's not mandatory and it doesn't interfere with our ability to do our -- to do business of insurance.

I would suggest to you that it's probably a good idea to at least take the next step and appoint the Director to move on to discuss it.

The only other comment I have to make that's peripherally associated with this is that over the course of the last four months, I have been trying to find re-insurance for my companies because we're a small operation, we write limits up to $10 million for our hospitals, most of which is re-insured because of our size.

And literally spoke to everybody around the world working in this market. And I just want to mention to you that the one question that comes up invariably is, What do you think's going to happen with the Scott decision? I think we've got to get that resolved. And I think that gives a little bit more predictability to the marketplace. And if a JUA is available and necessary, good; if not, that's good too. Thank you.

MR. LAKIN: Any questions panelists?

Mike, thank you.

Bill?

MR. SPENCER: Yes. Mr. Director and members of the panel, my name's Bill Spencer. I'm a local attorney residing in Jefferson City, Missouri. Today I'm appearing on behalf of Podiatry Insurance Company of America. I have a few prepared remarks and I will proceed accordingly.

Podiatry --

MR. LAKIN: Could you tilt the mic closer? Maybe tilt it down a little bit.

MR. SPENCER: Podiatry Insurance Company of America, otherwise known as PICA, has an application pending before the Department of Insurance as part of the overall effort to convert from a risk retention group to a fully licensed mutual insurer.

PICA's currently licensed in 23 states and has

applications pending or about to be filed in 16 additional states and the District of Columbia. PICA has a fully owned subsidiary PACO insurance company and is already admitted in Missouri.

PICA was founded in 1980. Their home office is Brentwood, Tennessee. With the sponsorship and assistance of the American Podiatric Medical Association, APMA, it has grown to the country's larger provider of professional liability insurance to podiatrists with almost 9,300 policyholders. PICA group also insures almost 5,300 chiropractors, mostly through its PACO subsidiary.

As of May 31st, 2003, PICA had assets of 140 million and surplus of 44 million, the statutory basis, and on a gap basis we have assets of 186 million and surplus of 65 million.

Currently PICA insures 143 -- 148 podiatrists in the state of Missouri and 46 chiropractors. That is approximately 80 percent of the podiatrists in Missouri. Over the last six years, PICA had direct premiums earned of 1.96 million on its Missouri business and wrote to a loss ratio of 70 percent.

However, we shared the concerns expressed by our colleagues regarding rising premiums and claim costs in Missouri. Over the past three years, premiums have risen 44 percent and in 2002 we had direct losses incurred of --

of 818,000 against direct premiums of earned of 804 -- excuse me -- 480.

While not approaching rates paid by specialists such as OB/GYNs, a Missouri podiatrist now pays $10,549 for a mature claims-made policy with limits of 1 million, 3 million without discounts.

Missouri podiatrists do not face the crisis of availability in podiatry that physicians of other specialities and in other locations have experienced. Indeed, rather than withdraw, we are seeking admission; however, we share to some extent the pressures of the hard market. And unless remedial actions are taken, we would expect continued increases in losses and rates.

The need for meaningful tort reform with a $250,000 non-economic limit is essential to keep control of malpractice rates.

MR. LAKIN: How do you feel about medical malpractice insurance availability for the long-term market?

MR. SPENCER: I'm sorry. Say again.

MR. LAKIN: I said, what's your position and what's the podiatrists' position on availability? That's what we're talking about.

MR. SPENCER: We feel there's availability there.

MR. LAKIN: Okay. Do you think a Joint

Underwriting Association should be established?

MR. SPENCER: I'm not sure I've got a definite opinion on that one way or the other. I think it may be a question of time. You mentioned a crisis. These things are cycles. These things are in cycles.

I think there may be a need to study it a little more, but I'm not quite confident that we need it at this juncture. I'd be willing to consider it as far as the upcoming position.

Let me just finish. Our rates have increased the past two years because four issues and these are the four issues we consider: Increase in severity payments; increase in frequency; increase costs of re-insurance, especially after September the 11th; and less investment income.

MR. LAKIN: Are those statements based on podiatry statistics only?

MR. SPENCER: Yes. The company's position.

MR. LAKIN: So you've had a increase in frequency from foot doctors --

MR. SPENCER: Yes.

MR. LAKIN: -- as far as lawsuits?

Any questions from the panel?

Bill, thank you. I know you've got a granddaughter with a birthday you need to get to.

MR. SPENCER: Yes. Thank you. Appreciate it.

MR. LAKIN: Steve Buie, with the Greater Kansas City Metropolitan Medical Society and Dr. Jeff Thomasson with St. Louis Metropolitan Medical Society and Missouri State Medical Association.

DR. THOMASSON: Can everyone hear me okay?

MR. LAKIN: Before you all get started, we've got about -- actually we're a little bit behind, but I'm trying to get out of here not too much after 12 noon so people can take their hour lunch break.

When we do break, I'm told that David Cox's handout of written testimony based on what he verbally said earlier is available over here by the door. So if any of you want written testimony or copies of David's written testimony, that is available for us right now.

And with that, Steve, you or Jeff is this a coordinated --

DR. THOMASSON: No.

MR. LAKIN: It's not. Okay. Jeff, why don't you go ahead and we'll follow up.

DR. THOMASSON: Director Lakin, panelists, thank you very much for allowing me here to comment on the availability of medical liability insurance and the need for creation of a Joint Underwriting Association in our state.

For most Missouri physicians, the present and

principal problem is one of affordability of insurance, rather than availability. Average premium increase for MSMA physicians polled in 2002 was just over 60 percent.

My own group of radiologists and radiation therapists had an increase of between 94 and 97 percent of each of our members in 2002. And we are not in as high a risk group as other specialities. We anticipate a similar increase this August.

But physicians in other specialities have had higher increase in their premiums compared to our group. Some physicians have been informed that their liability insurance policies will not be renewed this month or last month or to continue coverage with their carrier, the terms must change.

For example, they might have to pay a huge -- have a huge deductible like $100,000. They might have to alter what they do in their practice, like not delivering babies, not doing brain surgery for neurosurgeons or as a pediatric neurologist told me two weeks ago, stop their urban hospital teaching appointment to reduce their rates.

MR. LAKIN: Jeff, you said you had a 94 percent increase in your radiology group. Did you change deductibles or anything like that?

DR. THOMASSON: We haven't.

MR. LAKIN: The same policy?

DR. THOMASSON: We haven't done anything. And we're not sure what we're going to do exactly this year. Our renewal date is coming up.

These physicians can still get coverage, but at a great personal cost or cost of access to their patients. But there is a small percentage of physicians who cannot get liability insurance from the usual insurance companies and they're without hope unless they can get surplus line coverage.

If they are successful in obtaining this type of coverage, it can be at a cost of 200 percent or more of their present premium.

If created, the JUA can help these physicians, but if the insurance premium the JUA establishes is less than the surplus line premium or equal to it.

When I read the statute, I was distressed by the fact that the first-year premium is accompanied by a surcharge equal in amount to that premium for the first year. That financial penalty would be too great for some physicians to afford who are barely affording their conventional insurance. Also, this does not include tail coverage, which can be an expense equal to or greater than a year's premium.

At best, the JUAs a short-term stopgap solution. Experience has shown it's difficult to price

premiums that are affordable without putting the state at risk for being the sole insurers. A lot of states don't want to be in the insurance business.

In recent action, Nevada and West Virginia set up JUAs in 2002 and legislation authorizing a state-JUA passed this spring in Mississippi. West Virginia is phasing theirs out in favor of a physician-owned mutual which got the go-ahead, and state capitalization, in March of this year.

West Virginia's JUA was required to price premiums higher than what was available in the commercial market. In Nevada the state-run insurance fund is still operating a year later. Rates are not really competitive, although there are few companies writing.

One positive thing in Nevada's program is the state regulators prohibited the JUA there from imposing a terrible surcharge on obstetric doctors' premiums based on the number of premium -- of deliveries they do each year. And that has been a policy which was in effect in Nevada. So their state-JUA is not doing this.

The National Insurance -- National Association of Independent Insurers has advised physicians to check surplus lines before insuring with a JUA policy. Michael Zoziol, senior director and counsel at NAII, says state regulators should not impeded this natural competitive

process before its clear that surplus lines aren't working in these problem areas. The result is far better for everyone than the artificial mechanism of forming a JUA that forces licensed insurers to bear the risks involved ultimately at a higher cost for all consumers.

In addition, he states further that he does not feel a JUA should be ahead of surplus lines in the hierarchy of markets.

That being said, the idea that was mentioned by one of the panelists about having a person use a surplus line first and then if they can't do it, kind of a pass-through to the JUA seems like a reasonable idea. That's a good idea.

If a formation of a JUA would keep even a few Missouri physicians from stopping practicing medicine, it would help. It would be interesting to know exactly how many physicians in Missouri are unable to get insurance at any price.

In determining the need for a JUA in our state, the potential fiscal note to Missouri, the costs to consumers and insurers must be considered. Potential cost of creating this program has been speculated to be as high as $33.8 million depending on the number of subscribers.

Although the insurance companies get tax credits -- state tax credits for doing that, that, in turn,

comes out of state revenue. But that might still be a reasonable cost depending on the number of lives affected and saved.

It will remain the hope of Missouri physicians and their patients that meaningful tort reform can be enacted that will have a positive effect on the availability of affordable medical insurance in our state. The creation of a JUA, while it helps in the insurance availability, does not address this crucial issue.

We appreciate the Department's help in considering the creation of a JUA as a safety net for healthcare providers. Thank you.

MR. LAKIN: Jeff, the estimated $33.8 million cost, where did you get that figure?

DR. THOMASSON: It was -- there's -- I'm blanking on the name of the -- there's some oversight organization here in Jefferson City that listed it as an estimate. Another --

MR. LAKIN: Could you dig a little deeper and get that information to me?

DR. THOMASSON: Yeah. I'll get that information to you. There was also another -- akin to that, I think it was Senate Bill 1204 and earlier Senate Bill 550, the estimates for a JUA under those circumstances was about 23-point-something million.

MR. LAKIN: As a former legislator, I'm not sure fiscal notes is a good judge.

DR. THOMASSON: It's a scary fiscal note. I agree with you. I agree.

MR. LAKIN: All right. Thank you.

Any questions from the panelists?

MR. DOERNER: Yeah. I have a question. We have heard of anecdotal stories of doctors who have left the profession or who have moved out of state because of the medical malpractice insurance costs. Are you aware of anything like that?

DR. THOMASSON: Oh, yes. Absolutely. The Missouri State Medical Association has kind of kept an unofficial tally of doctors who have left the state or who are giving up practice, retiring early. But that's not the entire capture because that doesn't include non-member physicians in Missouri.

MR. LAKIN: Jeff, thank you. It's good to see you again.

DR. THOMASSON: Thank you.

MR. LAKIN: Steve?

DR. BUIE: Thanks for allowing us to come talk. I'm talking with several hats I guess today, past president of Metropolitan Medical Society in Kansas City and presently on the board for Missouri Academy of Family

Practice.

And I am a member of a family practice group that used to be eight. And we've had four of our folks leave the state for Kansas because of affordability reasons. I'm living proof. Part of the reason I'm spending time taking out of the office today and not seeing 40 patients today to come down here and talk about it because it's a real issue. It's happening by the day. We can't address this issue fast enough.

At the interest of being brief, I've enclosed interests from Richard Roberts, who is the head of the American Academy of Family Practice, past president, who is a lawyer and a medical doctor who is one of the most renown as far as reviewing data on what reforms work for medical malpractice relief. And I've enclosed that information.

I've also enclose information about the Pennsylvania JUA experience in that as well. And so their experience. I've also coupled data about what happened in Pennsylvania in spite of their JUA rates are still up, coverage is still difficult. Like you say, it's been no magic bullet.

The State of Missouri --

MR. LAKIN: I've had extensive conversations with my friend Diane Koken from Pennsylvania who is my counterpart there. And I wouldn't say we're lucky to have

the situation in Missouri, but we're lucky it's not the Pennsylvania situation. So --

DR. BUIE: The State of Missouri is currently experiencing its third and worst medical liability practice in 30 years. Patient access to necessary physician services is already in a broken system and is growing more narrow.

Physicians are relocating to neighboring states, pursuing early retirement, cutting back risk related but necessary healthcare procedures in order to maintain the viability of their private practice, which is overwhelmingly a small business enterprise in our state.

Missouri has historically had low reimbursement for healthcare delivery compared to neighboring states as the DeFrain/Mayer study has validated. And while at the same time, liability caps have been eviscerated in the courts while awards have been accelerated.

From 32 companies providing coverage for physicians in practice down to 5 by the coverage of May of 2002, only 5 remain to write new policies. Even when coverage could be found, rates in our state have risen for some specialties as much 200 percent in the past three years.

Physician recruitment is severely compromised in this environment. We export physicians from our state

and that acceleration continues. Access to patients is going to suffer.

While new companies have announced their intention to do business in our state, providers have yet to find affordable rates that would allow them to continue to pursue the practice of medicine.

Especially troubling is the decision by Saint Paul, the nation's largest and most experienced medical liability carrier, to stop medical underwriting in the business after 65 years. They've determined you just can't do it without substantial reform.

Critics maintain that excessive litigation is not a difficulty and that poor insurance management, stock market return, negligent providers serve as root cause of the crisis. In fact, two-thirds of the industry's assets are in bonds, which have held their value during the economic downturn while just 21 percent are in stocks.

Claims against healthcare providers actually decreased 31 percent from 2000 to 2001. And 7 of 10 claims are settled with neither payment nor negligence, but still cost tens of thousands of dollars to defend. Even judicious practice is met with unaffordable rate increase.

In point of fact, much of the increases in Missouri's medical malpractice rates were caused by one court case, the 2002 St. Louis case with Scott versus

Shawnee Mission Saint Luke's. It's been cited by insurance industry officials as creating potentials for unpredictable medical malpractice verdicts.

The case altered law in the state by making it possibly for courts to multiple the effect of the doctor's negligence and increase verdict awards from court levels. That's why we went from 32 companies to 5. That's the problem. That's the market.

Director Scott Lakin, as noted in press releases, is a good example of their decisions effect. In 2001, licensed insurers estimated the payouts on claims filed totaled 79 million. In 2002, the estimated amount increased to 168 million, 113 percent increase.

The result, Lakin said, that in 2002, healthcare providers overall paid 156.1 million in coverage, an amount that was 58 million or 61 percent more than 2001. These increases occurred even when the state didn't see a jump in large verdicts. Claims actually went down 6 percent.

The Scott decision must be rectified for any reform to be meaningful. I think I need to say that again. The Scott decision must be rectified for any affordable reform to be meaningful. I think without a doubt we had a market that was vigorous and competitive and unless we address this -- and I hope to take home messages for this

panel that if we pursue a JUA, it's very small selected target. You're talking in single digits of the market.

We have thousands of Missouri physicians hurting and considering their futures of practice here. That affects the health of our state. We need to ensure that all these folks get support that's needed.

If we have 30 million that assess the underwriting, I think in some ways we'd be best not to form a JUA but subsidize practices directly. Help them with their economical toil until the Scott decision and other medical tort reform is remedied.

MR. LAKIN: Steve, I want to be real clear. I'm sure you know this, but I don't think I've given any indication at all that a Joint Underwriting Association, you know, as I said earlier, is the silver bullet, you know. There needs to be other things done as well.

DR. BUIE: I agree. I think there are many things that have a much larger, more important impact. And the concern I have is with the attention of this, that we're pretending that we're doing something that will be substantial.

And I think most practitioners in our state really feel that a JUA is a very small slice of the pie, very small slice of the pie and that there are actually risks of a JUA. It may be the only insurer of only resort

for some of the most marginalized physicians.

The fact is in other states physicians with some of the worst histories have gravitated to the JUAs because no one else will insure them, exactly getting after the issues that we have providers that are marginal. The State actually can be an accomplice to malpractice in some of these issues. So there is a downside to this.

I think the concern is that we keep our eye on the ball and do what's important, what's doable. We think we need to start somewhere, but let's not frit away a lot of time and resource on issues that have been proven nationally in other states, other models that haven't really seen a lot of impact. And I'm afraid the JUA may fall into that category.

MR. LAKIN: I guess I know I've arrived as a player when they start throwing quotes out of press releases back on me in testimony, but --

DR. BUIE: The minute's come.

MR. LAKIN: -- I appreciate it.

Any questions from the panel?

MR. JONES: Just to make it clear, Doctors, both of you, are you both recommending or advocating that we do or do not establish a JUA?

DR. BUIE: I don't know that it will make that much help, frankly. I mean, I suppose you can do it. I'm

not very sanguine about it. I think most practicing physicians will move out of the state, will curtail practice, will retire earlier, will look for another avenue rather than pay a twice assessment in a market that's already unaffordable for a practicing physician.

That's been the experience in my personal practice. It's just easier to pick up and go to a state that's more enlightened.

And so I suppose we can do it. I don't look that it will be that much of a help.

MR. JONES: I guess that --

DR. THOMASSON: If it's the court of last resort, better have that available than a physician -- assuming they're practicing safely and prudently, just had unfortunate experience, it would be better than no safety net at all.

MR. JONES: Thank you.

MR. LAKIN: Any other questions?

Thank you both, gentlemen.

We are scheduled to break for an hour. I'd say be back here at one o'clock. But we're going to break until 1:00. Thank you.

(A RECESS WAS TAKEN.)

MR. LAKIN: I've got a couple last-minute, I guess, changes on the afternoon schedule. One of the people

testifying had an emergency surgery and won't be here, Dr. Michael Reynolds. But we'll start this afternoon -- I don't see Delia Young here, so we'll go ahead and start with Dr. Tom Kelley representing the Missouri Academy of Family Physicians and Bonnie Bowles, Missouri Association of Osteopathic Physicians and Surgeons.

Mr. Kelley, welcome.

DR. KELLEY: Thank you. I'm Dr. Tom Kelley, K-e-l-l-e-y. I'm a family physician, vice president of Missouri Academy of Family Physicians and I practice at Seaport Family Practice in Liberty, Missouri and I've been in practice for five years.

The Missouri Academy of Family Physicians recognizes and greatly appreciates the Department of Insurance's efforts in regards to this very distressing situation for Missouri's citizens, physicians and patients.

An entity that offers physicians choice and avenue for coverage when an insurer determines to no longer provide insurance to physicians, as has happened since discussion of this issue exploded last October, can be positive if it will allow physicians to provide ongoing care while providing a bridge to market insurers.

However, the JUA does not address the underlying cause of affordability of coverage. For example, in my practice, in 2003 we saw an increase of 98 percent on

our insurance compared to 2002.

In 2004 -- I just talked with our insurer earlier this week --

MR. LAKIN: And that was without a JUA. Right?

DR. KELLEY: That's without a JUA.

In 2004, we are looking at a 25 to 50 percent increase for our practice. In our practice we're also looking at limiting the scope of services and making significant cuts to the practice in order to recover these losses.

We're concerned about the possibility of unintended consequences as a result of a JUA. Cost to Missouri taxpayers is a concern and in interest of allowing -- excuse me -- and in interest of patient safety, allowing the uninsurable physicians to use this as a last resort is a concern.

We're also concerned about how physicians will be rated in regards to the determination of rates, thus, potentially diminishing competition within the state. We're concerned about the amount of time it will take to establish and fund the entity, because my colleagues and I are already eliminating and limiting our scope of services they provide due to the cost of coverage.

In essence, Missouri Academy supports a JUA;

however, we're concerned that it may not be enough to stem the tide. Entertain any questions.

MR. LAKIN: I think in my opening comments I mentioned that within the next week or two the Governor will be announcing the Commission on Patient Safety. And you think that combined with a JUA would help?

DR. KELLEY: I think when we really look at measures to help us, I think that -- and it has been mentioned before by my colleagues preceding me here that the Scott decision and tort reform are two critical issues that have to be addressed. And the failure to do that in this legislative session is having a significant financial implications not only to my practice, but physicians across Missouri.

MR. LAKIN: Do you think that establishment of a JUA would hurt either of those two --

DR. KELLEY: I don't think it would hurt. However, I don't think the JUA is necessarily enough.

MR. LAKIN: Okay. Any questions from the panel?

Bonnie?

MS. BOWLES: Good afternoon. I am Bonnie Bowles, and I represent the Missouri Association of Osteopathic Physicians and Surgeons. And

I would be remiss if I didn't thank the

Department of Insurance for calling this meeting today. I will tell you that I considered seriously not coming today because basically I have the same message that I had last October, but I was asked to reiterate that.

Any help the physicians can get would certainly be appreciated. However, I do believe that a JUA at this point in time is a Band-Aid approach to a major problem.

We certainly would not oppose it. As you know, Mr. Lakin, we basically had a company that we would have liked to have had established through legislation last year, which would have been a mutual company ran by physicians. It would be partially regulated by the state, much like the workers' comp. We believe that that was a better alternative.

We would have put some stopgaps in it where we would have companies that didn't shut down when the market got good, leaving our an physicians with a tremendous amount of assessments and liability. We thought that that was good.

We also thought insurance regulation was important. Not just premium increases, but have you set your rates at something that's actuarially sound as a positive.

Tort reform and the Scott case is absolutely

essential. As you know, the insurance companies who are selling -- the legitimate companies who are selling here in the state of Missouri are going to hit our physicians with another increase next year trying to build their reserve to cover the Scott decision. That's another major issue.

I remind everyone here today, you know, we're focusing on a couple of small things. It sounded to me this morning that we were concerned that first in October we didn't have enough insurance companies, now we have a few of them and people are concerned about their turf.

MR. LAKIN: Having too much now?

MS. BOWLES: Yes. My concern --

MR. LAKIN: See the tough job I have as director?

MS. BOWLES: My concern is simply for the quality of healthcare for the citizens of this state. And I don't want to lose focus of that particular issue. I want to remind everyone here today, does it make any difference if we have 10 companies or 100 companies?

What the healthcare delivery system has done to physicians is simply this: You have done everything to control their revenues and nothing to control their costs. That's where we are.

You can have a JUA, but if you are going to assess them double their premium, it is not going to make a

difference. They're going to leave Missouri, they're going to retire early and they're going to stop procedures. And that is going to be important to any of us who have to access the healthcare system.

It is not a political issue. It is a healthcare issue. And it is going to be a crisis in this state for the citizens that need healthcare. We are now the proud owners of being stated in national magazines as being one of the states in a malpractice crisis.

We need medical malpractice reform. We need a mutual insurance company that isn't going to leave the physicians at the first time the first buck is lost and we need insurance regulation.

We need to make sure that companies that come into this state set a rate that is actuarially sound. Not just high, but the low end also.

MR. LAKIN: Bonnie, do you think establishment of a JUA could help do that?

MS. BOWLES: You know, unfortunately, I can't tell you that I have the expertise, but I do think --

MR. LAKIN: Some of the testimony we heard this morning from the actuary about data and data collection and having more Missouri specific data, it seems to me that would also tend to help other writers in Missouri understand what their risks actually are.

MS. BOWLES: I certainly don't think that the JUA is going to hurt the marketplace. Any time you have competition, that's good. And at least the state would have a vested interest -- more of a vested interest in it. But I just don't want to see us focus on that small piece and forget the big picture. And --

MR. LAKIN: I don't think we're doing that. I think, again, as I mentioned earlier, this is a small piece of it --

MS. BOWLES: Right.

MR. LAKIN: -- certainly an option we could add, sort of another arrow in the quiver to give some choice to physicians.

MS. BOWLES: But when we talk about access, it doesn't make any difference how many companies we have if the physicians can't afford it.

When you have Medicare paying 33 cents on the dollar, you have Medicare paying less than usual, reasonable and customary and you have managed care discounting the physicians, they can't take their revenues and increase them like business can and spread it over their consumers or the service that they provide. Physicians are locked into a fee.

MR. LAKIN: Well, we're trying to address that to the best of our ability, as I mentioned in my opening

statements about the prompt pay and making sure that we hold companies accountable to follow the law in prompt pay.

But I guess my question -- and we heard testimony this morning from other groups representing physicians in the state, that we don't have an availability crisis, we have an affordability crisis.

And my question earlier was if it's not affordable, isn't it not available? And I'd be interested in your comments on that.

MS. BOWLES: Well, I'm not too sure we don't have an access problem to some of our specialty groups. And the reason -- I agree a little bit with you, Mr. Lakin. We've had some of our top osteopathic physicians, specialists leave the state of Missouri because they simply could not pay the malpractice. So that to me is accessibility.

And then we have some who are going to leave because they're going into their retirement accounts to keep their practice open and they don't see that as a very viable option. So when you ask me is there accessibility? No, there isn't. Not when you're charging physicians such a premium that they can't afford to stay in business.

MR. LAKIN: Okay.

MS. BOWLES: And that is what a small practice is or a small group, a business.

MR. LAKIN: Any questions from the panel of Bonnie?

Thank you, both of you. Appreciate it.

Let's see. Next on the list is Rebecca Speake, Cretcher-Lynch & Company. And also John Bisaha, Jefferson City Medical Group.

Hi, Rebecca.

MS. SPEAKE: Hi. My name is Rebecca Speake. I'm an insurance agent, an independent broker with Cretcher-Lynch & Company based in Kansas City.

I spend the majority of my day working with physicians all over Missouri and Kansas, so I feel like I have a lot of experience. And lately my job has become very difficult. I've been doing this for a number of years. I went through the crisis in the mid-80's and this is far worse, in my opinion, in my job finding coverage for physicians.

I agree wholeheartedly with Dr. Buie and Dr. Thomasson that tort reform is desperately needed, but I also feel strongly that we do need a JUA. I know personally of a number of physicians in Missouri, particularly rural areas, that have either taken early retirement or they've moved out of state because they couldn't afford their insurance renewal.

I have personally helped quite a few

physicians in the Kansas City area who owned a home on the Kansas side but practiced solely in Missouri and didn't have a Kansas license. I've helped them get their Kansas license or reactivate their Kansas license simply so they could get coverage, because they couldn't get it from one of the carriers in Missouri.

I have seen a number of physicians who, because of the rising cost of tail coverage on their claims-made policy in Missouri -- and Kansas won't allow them to bring their prior acts into Kansas, that have gone bare on their tail coverage. They've had many years of practice and couldn't afford to pay the hundreds and thousands of dollars that it took for tail coverage and had to start on a brand-new, first-year, claims-made policy hoping to not get tagged and move their assets to their wife's name, whatever their tax attorneys helped them do just to try to protect their retirement from the malpractice.

I agree that the price crisis is part of it. We write with a number of excess and surplus lines markets. We write with all the standards markets with the exception of Missouri Physicians Mutual in the state.

And we're seeing more and more strict underwriting guidelines move a good physician that's had bad experience -- limited bad experience even to the excess

surplus lines markets. A couple of examples, a urologist that paid $17,000 last year, the best quote we could get for a first-year claims-made policy in Missouri was $94,000.

Then you have the brokerage fees and the Missouri tax and everything on top of it. And he's looking at a minimum of 200 percent of that for tail coverage after one year.

Family practice doctor that went from paying $10,000 to $45,000 for a first-year policy. Emergency medicine is a real tough area to find coverage. If a doc is in the ER field and has had a couple of claims, we're having a devil of a time finding coverage for them. 55,000 is the lowest that I can find. And that's, again, a first-year claims-made policy. They require that they purchase the tail coverage, you got the taxes and fees on top.

Other problem areas are cosmetic/plastic surgery, bariatric surgery. We're finding a difficult time all of a sudden for physicians who serve as medical director at a nursing home. None of the standard markets want to write a doctor that is serving as a medical director at a nursing home. So that's another area that's become a problem.

We've been contacted by a number of physicians who provide medical care to prisoners on a part-time basis so they're not covered as employees of the federal

government. Even the excess surplus lines markets don't want to write coverage for the prisoners. The feeling being that they're incarcerated, they don't have anything else to do but file bogus malpractice claims.

Part-time in general is a problem. I have a physician just the other day who is in a fellowship program at MU in Columbia for a year. He wants to work part-time -- as any of the physicians in here know, you can't make a living that way. He wants to work part-time on weekends for a family practice clinic. Board certified in family practice, but he's furthering his education.

Medical Assurance, Medical Protective, none of the carriers that I write with will write a part-time policy. They see the exposure as too great for what would normally be considered a part-time premium.

We went to the ENS market, he would have paid every dime plus more for a policy through the ENS market then he would have made working weekends for the family practice clinic. So it didn't make any sense.

I think the JUA is needed, but I think it needs to be set up with some good guidelines. I do a lot of work with the Kansas availability plan and they do require letters of declination before a doctor is eligible for coverage. I definitely think we need to follow those guidelines.

We need to charge reasonable rates, but not -- you don't have to be competitive with the standard markets. The standard markets should still take the bulk of the share of the doctors in Missouri, but I don't think that we should go crazy like the ENS markets have.

Sometimes I wonder if they're picking numbers out of the air, because I can get a quote one day for a specialty with a doctor with similar loss history as what I got last week and the numbers are so vastly different it doesn't make any sense.

I think you should use agents to make your submissions to the JUAs. And I know that you may think that that is selfish, but there's two reasons for that. One, because the agents that deal with the malpractice coverages can help to make sure that the doctor cannot obtain coverage from any of the standard markets and help him get those declination letters, but also your staff would not need to be as big because the agent should be able to help gather the information you need for underwriting as opposed to going back to the doctor or the doctor's business manager and requesting additional information.

Most JUAs that I have ever dealt with require quite a ream of paper before they will issue a policy. And that can be very cumbersome for the doctor or the doctor's business manager to deal with.

The Kansas JUA is successful, but I recognize that they did not fund by assessing the carriers. They funded the JUA by the Kansas stabilization fund, by the advent of that. So we don't have that available to help fund ours. I know that the budget is in the red and we don't have the money readily available.

I agree that it is a Band-Aid situation -- solution, but it would -- with the situation we're in now, it would at least solve the problems of some of the doctors in these high-risk specialities.

Even if a doc had a couple of bad claims, had been in business for years, the standard market wouldn't take him, if we could get him in the JUA for a couple of years until we can get things turned around, show that he's not a bad physician and then get him back out into the standard market, we would love to have a place to go.

Since the law requires that they carry coverage, it's making my job very difficult to find coverage for them when they are in these specialities or have had some unique claim problems. Thank you.

MR. LAKIN: Thank you. Rebecca, you seem to be saying that we don't only have an affordability problem, but we do have an availability problem for certain doctors because --

MS. SPEAKE: Yes.

MR. LAKIN: -- there's -- and from your description, it sounds like there are sort of niche doctors that are doing different types of care that sort of fall through the cracks of the normal standard private marketplace.

MS. SPEAKE: Yes.

MR. LAKIN: Is that an accurate reflection of --

MS. SPEAKE: Yes, it is. That has been my experience.

MR. LAKIN: Okay.

MS. SPEAKE: And, like I say, I write with -- other than Missouri Physicians Mutual, I have contracts with the other standard carriers and can access all of the ENS markets, so --

MR. LAKIN: Are a lot of your clients shifting over to Kansas?

MS. SPEAKE: Yes. Being in Kansas City, I see that on a daily basis. Overland Park is a popular place for physicians to live, Leawood and Overland Park anyway. Many of them already live on that side of the state but they're practicing in Missouri. We're finding that those physicians are applying for or reactivating Kansas licenses in droves.

My concern is that that's going to put a burden on the Kansas availability plan and they may stop

writing doctors that practice 100 percent in Missouri. Right now the law allows if they live in Kansas and have an active Kansas license, that they are afforded coverage.

MR. LAKIN: But these are good doctors? We're not just shipping the not-so-good doctors over to Kansas?

MS. SPEAKE: Well, I'm not going to make a judgment good or bad. I'm talking about everything from a family practice doc that had one claim settled for just over 100,000 to a surgeon who has had multiple claims and everything in between.

I mean, the underwriting guidelines with the standard markets have gotten so tight, you don't have to be a bad doctor to end up in an availability crisis or paying a ridiculous amount or going bare on your tail coverage because you can't afford to pay for a ridiculous amount of premium.

MR. LAKIN: It sounded to me earlier in testimony with Mr. Trout who runs the 383 that -- and I've seen this in my past life as an agent, where if you could just get those underwriters to look a little more in depth, you know, at, you know, who's behind this application, that many times they're willing to assume a risk they normally wouldn't have assumed on the face of the application.

And, you know, I know that you've probably have gone through that the last year or two where your

biggest problem is not dealing with people and whether or not they'll purchase the coverage. Your biggest problem is you're fighting insurance companies and underwriting staffs of insurance companies trying to get them to pay attention that this is not a type of risk that you shouldn't assume; is that --

MS. SPEAKE: Exactly. And they were a lot more reasonable before the Scott case. Ever since the Scott case, they've gotten so tight that they won't look beyond -- they're all requiring their own applications to be completed, which puts the doctors through, you know, a very difficult process.

As their agent, I do as much of the application as I can, but when you're looking at a Medical Assurance application that's 17 pages long and you've got a group of 12 doctors and they also want to go to Medical Protective to try to get a quote and they want to go -- you know, they're already with Intermed and getting non-renewed, it puts them through quite a process to try to convince -- and for me to convince the insurance company why they should be the exception.

MR. LAKIN: When you get three or four quotes, are they all over the board or are they pretty similar?

MS. SPEAKE: They're all over the board with the ENS markets in particular. Now, Medical Assurance,

Medical Protective, the Doctors Companies rates, even KaMMCO is writing -- the company that was started by the Kansas Medical Society started writing just in Kansas, they're writing in the Kansas City area. They've even quoted a couple of things for me up in St. Joe. They don't want to go far into the state of Missouri because they don't feel like they can defend it. They have their own in-house counsel that comes over to defend. But all of their rates are very similar for most specialities.

MR. LAKIN: It seems to me that, as you said, if the rates were all over the board, when you --

MS. SPEAKE: With the ENS carriers, yes.

MR. LAKIN: Yeah. That that's an indication that companies are having problems getting a handle on what risk they're actually assuming.

MS. SPEAKE: I think that may be true. Sometimes I think it's -- because the ENS markets -- the rates are not regulated, they don't have to file them, I really do feel like some days I will -- if the underwriter had a glass of wine with lunch, I'm going to get a better quote than the day before when he didn't. It's that much of a difference from day to day on the numbers that you get.

MR. LAKIN: So you feel, as someone that's trying to place physicians, this would be a good thing, the JUA, because it gives you, again, as I said earlier, another

arrow in your quiver --

MS. SPEAKE: Right.

MR. LAKIN: -- to be able to maybe help doctors that do fall through the cracks because they have a unique situation or a unique lawsuit filed against them or something like that?

MS. SPEAKE: And, again, I see it to help a certain percentage. It's probably not going to be a huge number of physicians in Missouri. We hope it's not a huge number. I don't think that's what a JUA is really set up for or designed to do.

We hope that it is a small number of specialty classes or specialty areas or part-time doctors that the standard markets don't want to insure for at least a period of time. And maybe we can get through them some risk management classes, shown that they've gone a couple, three years without having any claim and get them back out into the standard markets at a reasonable rate.

Again, I agree with the comments made before, that tort reform is absolutely necessary to bring availability back in, but I think this would at least help some of the physicians in Missouri, yes. If it's set up properly.

MR. LAKIN: And I think that's sort of what I'm hearing from a lot of the testimony is we're not

necessarily against the JUA, it's not going to solve all the problems, we're concerned it has to be set up, you know, properly with properly -- proper safeguards. But if it's set up right, it could -- you know, it could or might be a help to the marketplace.

MS. SPEAKE: Yes.

MR. LAKIN: I've always thought that -- and getting -- since you're someone dealing with underwriters trying to get, you know -- trying to get policy offers to doctors and that kind of thing, you know, if I'm a patient and you're a doctor and I didn't like your bedside manner, and I really want to mess you up, I can do that. All I have to do is file a claim against you. It might be the most frivolous lawsuit in the world, but all I have to do is file a claim.

Why? Because I know it's going to screw you up on your medical malpractice premiums because, again, it might be the most frivolous lawsuit in the world, but it counts against you. And when you fill out that application as a doctor, Do you have any claims pending, you've got to put down, yeah, I've got this claim and, you know, let me tell you, it's the most frivolous thing in the world, but -- and the insurers don't care.

I mean, they don't -- and your challenge, it seems to me, and this is -- is trying to get that company to

look beyond that application to say, Yeah, you're right, this is a frivolous lawsuit and it will cost a little bit defense-wise to, you know, defend it.

But it seems to me that that's a big part of this problem. I think it was evident in -- and I said it at the time when we submitted our report to the Governor in February that, you know, the problem is we can't get the companies to look sort of beneath the initial application.

Yeah, you've had, you know, a lawsuit last year filed against you. Well, what are the details of that? Why was it filed against you? And to determine whether or not you're at risk in the future.

MS. SPEAKE: Not only do they have to put that on their malpractice application, but also any of the credentialing forms for the HMOs, PPOs, insurance plans, hospitals of which they're on staff.

The insurance companies want to look at the reserves set by the current insurance company that's defending that claim. The insurance companies that are defending the claims, because of the high cost of defense coverage and the Scott case, are slapping huge reserves on claims which makes it look worse than it should look.

MR. LAKIN: Well, yeah, and they've taken a beating the last few years on the investment side, but if I'm -- you know, if I'm a numbers cruncher at one of these

insurance companies and, you know, I'm going to miss, I want to miss high. I don't want to miss low, because we have lost money the last few years, that kind of thing.

And so I think we're seeing, you know, a real uneasiness in the risk acceptance. They didn't set it right -- their premiums correctly according to what they thought their risk was through the '90s.

Now I think we see the pendulum sort of swing back the other way where they're not setting it right because they're might be overly risk adverse in a lot of cases. I do think -- and we've been pretty public about it from the Department's standpoint -- that things like the Scott decision need to be addressed.

The reason I bring all that up is to get back to why we're here today and look at if the JUA could be a tool, not -- not the tool, but a tool that we could use to help at least in some cases with some of these doctors that are falling through the cracks or have certain niches, that they could be used as a tool to stabilize, you know, that area or stabilize that market so they know that they can get coverage.

And I think you're right. I think it -- how it's set up is going to be a key because, I mean, we do it with MC-Plus for Kids. We say, If you can't find coverage at 150 percent or less of what the average, you know,

premium is, then you qualify for this. We set certain parameters on all that.

And this program is nowhere near as large as that, but I do think that there could be parameters set on it so that, you know, it is a positive influence on the market and not a negative one.

Anybody else want to chime in here?

Okay. Thank you, Rebecca. I appreciate your testimony.

John?

MR. BISAHA: I think I'm probably going to cover some old territory, but the rapidly rising and decreasing availability of malpractice insurance nationwide is also an acute problem in this state. Some people seem to believe it isn't a crisis, but obviously Time Magazine feels it's a crisis as of the June 9th issue.

A lot of other people want to blame the insurance industry, the stock market. And while physicians recognize the complexity of the problem, the problem is really one that requires a lot of phases and a lot of -- a lot of complex issues that have to be resolved.

Somebody stated here this afternoon that the JUA is an arrow to solve the problem in the quiver. We don't need an arrow. We need a tank. We actually need an aircraft carrier coming in from all ends to solve this

problem. The JUA is only going to be a small portion of the answer to this complex issue.

Jefferson City Medical Group, who I represent, is one of the largest physician-owned multi-specialty practices in the state. We provide healthcare to over 60,000 people here in the capital city area. And many of our physicians have been trained at very prestigious institutions that have a reputation for excellent medical care.

Despite the favorable malpractice record, we experienced over the last 3 years, a 30 percent increase each year in our malpractice premium. And as of June, we had another 40 increase in our malpractice premium.

Our rates have risen extensively and other physicians in the Jeff City region have actually left practice and are no longer delivering babies. There is one neurosurgeon in Cole County who is running at a deficit primarily because of his malpractice. He is considering leaving Cole County. And I'd really hate to have a head injury if I was working anywhere in Cole County if that physician leaves.

MR. LAKIN: John, has your group, Jeff City Medical Group, have you had problems finding coverage?

MR. BISAHA: Actually, we almost were not covered this year. We had an extensive problem. And we

actually considered a captive. Part of the situation that we have is we're a large group, so it's complex.

MR. LAKIN: How many physicians?

MR. BISAHA: Over 60.

So when you say there are new providers for insurance here in the state, many of them don't even want to look at us because we're too big. There are only, like, two or three companies that would even consider us.

The other problem we have is that we don't want to insurance hop, because you do get a bad reputation in the industry to insurance hop. So you want to develop a risk management program with a company that you can work with, that hopefully keeps your rates down and you can manage your risk.

The other thing is some of -- the company that we presently have, when they sold us the insurance, gave us some perks. And one of those perks, for example, was that a physician that retires will get free tail. We can't get that with any change in any insurance. So it's difficult for us to change insurances because of the increase in tail coverage that you have to purchase just to leave your practice.

MR. LAKIN: So because your group's so large, your -- let's see how I ought to say this. You're at a disadvantage in a way because your group's so large because

only two or three companies will even consider writing you --

MR. BISAHA: Right.

MR. LAKIN: -- but you're also having an advantage because your group's so large because you cut sort of a special deal --

MR. BISAHA: That's right. On other parameters. But that prohibits us then to transfer insurances because no one else wants to cut us special deals in the market as it is now.

MR. LAKIN: Because the retired physicians don't want to give that up.

MR. BISAHA: Right. Right. So it winds up being a unique situation.

Now, if some kind of insurance change is made, it's only one piece of the puzzle. You can't -- anybody in a sane business -- and insurance is a business, and if I was doing an insurance plan in this state, you're going to need other things.

You're going to have to have limits on non-economic damage awards, you're going to have the provision for venue hopping. You have to reform this joint and severable liability rule. They are specific --

MR. LAKIN: But that's not under any of the JUA provisions in the --

MR. BISAHA: I know. And that's -- and that's a problem. But the situation is that --

MR. LAKIN: Do you think that -- do you think that establishing a JUA without all that other stuff would hurt the marketplace more than help?

MR. BISAHA: I don't think it solves the problem.

MR. LAKIN: And I don't think -- we've said it is not a silver bullet.

MR. BISAHA: It will solve certain problems for physicians that need insurance for certain reasons. But the problem is still there.

My problem right now is recruitment. I am recruiting something like eight physicians, specialists that I need in this area. And the doctors are telling us, Well, why should we come to Missouri? You're on the list of crisis states for malpractice.

Granted, we're not on top of the list like Pennsylvania and West Virginia, but we're having a recruitment problem. That's going to involve an impact on our patients. We're not going to be able to see a lot of the patients because we won't have the physicians.

MR. LAKIN: Do the physicians pay for their medical malpractice premiums personally or individually or do you do it as a group?

MR. BISAHA: What we do is we contract for the malpractice premium as a group, which gives us leverage. But each of our divisions -- for example, we have a family practice division or a --

MR. LAKIN: So if you've got a division of, you know, 10 OB/GYNs or however --

MR. BISAHA: They pay for it separately.

MR. LAKIN: -- they would pay more --

MR. BISAHA: Yes.

MR. LAKIN: -- in the group --

MR. BISAHA: Yes. Our surgeons, for example, had, I think, 140 percent increase. Overall, our group was like a 40 percent increase total. But some physicians hardly had any increase in malpractice, others had substantial increase in malpractice.

MR. LAKIN: So you didn't -- you didn't commute --

MR. BISAHA: Yes, we did.

MR. LAKIN: -- commute the rates across the board?

MR. BISAHA: No. We actually go back and the surgeons pay the higher cost and the family practice doctors pay the lowest cost, for example. We break it out according to what exactly their malpractice is based upon the specialty. So we get them to pay the individual premium by

the division.

MR. LAKIN: Okay.

MR. BISAHA: But that gives them a little break in trying to get a global package, but you know, we -- it's not fair to cover that as one group when a physician's malpractice is a lot less and another physician's malpractice is much higher than that.

MR. LAKIN: Yeah. It's all spreading the risk and how you allocate it and that kind of thing.

MR. BISAHA: That's true. That's true.

But I think what has occurred with us and one of the surprises we had -- I'm not reading this anymore -- is that when we were notified that we might lose our malpractice, we said, Why? I mean, we have -- hardly have any malpractice cases.

And what we were doing is the malpractice carrier says, When anybody ever calls you, please let us know. So a patient calls and has a problem and said, We're going to sue you, we're supposed to call our malpractice carrier. If we get a letter, We're going to sue you, then we have to call our malpractice carrier.

Each one of those was a black mark against us. So it's not the fact that they've gone to court or -- you know, now an attorney is assigned. Now there's a lot of cost involved because someone is there.

Nationally I think only 30 percent of the cases actually go to court and actually have some sort of monetary sum. 60 percent of the malpractice cases are dismissed for whatever reason, you know. You can say, but they still involve lawyer time --

MR. LAKIN: They still count against you.

MR. BISAHA: They still count against you. So the thing is you're talking about people filing meritless claims. It happens. And it happens because -- you know, and I can legitimately see that.

You're mad because your father died or your mother died. So you're going to file something because you want to get back at somebody because it was an uncontrollable event. None of my physicians support a patient's right and their day in court. And problems do happen. They happen in any industry.

But we want them to seek restitution in the true manner and get true restitution if there is a problem, not because it's a meritless claim and because we're going to get a black mark because someone files this meritless claim.

MR. LAKIN: I understand that. And that's part of the broader scope.

MR. BISAHA: That's part of the broader scope. This will be a small help in terms of the physicians in

Missouri, but it will not resolve the problem. I agree with the other individuals in the audience. It has to be looked at in terms of tort reform, has to be looked at a number of other items or it will not get resolved.

MR. LAKIN: Well, and as you're probably aware if you've read the Department's report we put out in February, we had about 20 recommendations, you know, that could help the situation and I think that this was just one of those.

MR. BISAHA: That's true.

MR. LAKIN: So we've been very clear that it needs to be more comprehensive, but we do think this is worth looking at.

MR. BISAHA: I would agree with you it's worth looking at. I guess that I'm frustrated with some of the other people and the fact that there seems to be a thought process of saying this is not a state crisis.

It is a state crisis. It's happening right now. And I think the public is the one that's going to suffer. And I think some major decisions have to be made within the state to really control this situation. You're trying that in your own small way.

MR. LAKIN: Well, and I would agree with you it is a crisis, because I've dealt with it every day for the last year. Something on my desk has been dealing with this

situation.

MR. BISAHA: Right.

MR. LAKIN: So, you know -- and, again, as I said in my opening comments, I think we've been proactive as a department trying, you know -- trying to do things behind the scenes many times and trying to do things as far as licensing new insurers, keeping bad actors out so that physicians and victims of medical malpractice aren't victims again.

And, you know, trying to do things like strengthen and enforce our prompt pay laws so that physicians, you know, are able to get their accounts receivable in as quickly as possible and relieve that problem.

And so we've taken on a number of fronts, you know, looked at that and obviously it's been an issue that's gotten a lot of attention over the last --

MR. BISAHA: Right.

MR. LAKIN: -- year or so.

MR. BISAHA: And I think the insurance commission, exactly like you're saying, has been very, very positive and helpful in terms of what you've done here in this state. It's just that --

MR. LAKIN: I'll just say this and then I'll let others talk if they want. I said this a year ago, that

at some point we've got to get past the finger pointing stage and we've got to sit down and -- I thought, just from personal opinion after the legislative session, the sad thing was there was a lot of areas of common ground from all sides that I thought we could have done something. But now we're past that, we've got to get over that and look toward the future.

And I know the Department will continue, you know, doing everything they can within the scope of their authority to try to get through this crisis. And, you know, I worked for 10 years in the state legislature on healthcare and health reform and I want to get off of these types of issues, quite frankly, and get them solved so we can go back to the old days where we used to worry about the number of uninsured in the state and those kinds of issues as well.

So that's my platform speech a little bit, but I just think it's important to understand and sort of put in perspective, you know, where we're at. We're got to look forward, not backward and try to do everything possible in order to solve this situation.

MR. BISAHA: And the group I represent also wants to solve it. We're here in Jefferson City and we want to cooperate with any of the agencies in terms of developing a plan that would be beneficial to all the physicians in the state.

MR. LAKIN: Well, and I want to be very clear. You know, this is something I'm looking at from an objective standpoint. There's been no pre-determined decision here. And I've got a weekend and early next week I'm going to have to, you know, really ask a lot of questions and do some contemplation.

But, you know, again, I think that I would have been negligent in my duties as director if we didn't bring this up as an option at least for consideration because, again, we've made the commitment as a Department to do everything possible to ease the situation that we're faced with right now.

Anybody else? Mark?

MR. DOERNER: I just would make a comment that the statute requires us to hold the public hearing before we set up the JUA. So for anybody wondering, you know, why we're having this big a meeting and so forth, we have to do it if we want to set up a JUA. It's a condition precedent to going forward.

And it doesn't mean that this is the only issue that's out there. We recognize that there are other things to work on, but we can't do anything with the JUA even if we wanted to until we take this step.

MR. LAKIN: Any other questions?

Thank you both. I appreciate it.

All right. Let's see. Delia Young? Is Delia here?

Okay. Are there any other public comments from anybody in the audience that would like to come forward?

Why don't you come forward and please state your name very clearly and who you represent so that it will be entered into the official record. Welcome.

DR. TETTAMBEL: Thank you. My name is Melicien Tettambel. I'm an osteopathic physician --

MR. LAKIN: You might want to spell that later for the benefit of the record.

DR. TETTAMBEL: Thanks. I practice in Adair County, I'm board certified in obstetrics and gynecology and osteopathic manipulative medicine.

I stopped delivering babies last year because of my malpractice rates. I practiced for 15 years previously in Chicago, the famous Cook County, home of lawsuit city.

I came back to Missouri because I am from Missouri. I have an opportunity to teach at the Kirksville College of Osteopathic Medicine and have a private practice. I'm speaking for myself, for the students of Kirksville Osteopathic College of Osteopathic Medicine, because I have a teaching -- I have a teaching appointment.

When I left Chicago, my malpractice was $75,000. When I came to Missouri, it was $29,000 for one year. At the end of that year, Zurich Insurance Company told me they were no longer writing in Missouri, but they would see if they could help me find other insurance. They were very helpful to the tune of $150,000.

Well, that did leave me breathless and I inquired, well, why would this be? Well, does Hurricane Andrew sound familiar and Twin Towers? Zurich insured these entities. And -- well, you know the rest of the story, as Paul Harvey would say.

So I found it not really a good idea to pay $150,000 and for a while I thought about going to back to Chicago, but I have family here and aging parents and I enjoy teaching and I like Kirksville.

I'm a female obstetrician/gynecologist and I was enjoying a very positive situation in my practice. And there were two of us board certified female obstetricians in the area, another lady I believe is either in Macon or Moberly. Neither one of us now practice obstetrics and gynecology.

My concern about the JUA is to have some thoughts about -- I like your term "unique doctors," because in my filling out, oh, gosh, it seems to me like millions of applications no less than 17 pages a piece, took a lot of

time and effort and I burned out a couple copy machines to hear that, Well, no, it's not going to be less then $150,000, I'd have to empty whatever I have out of a retirement account.

I have to think very carefully whether I want to renew my teaching contract. Because I teach, that escalates insurance payments. And if I ask the Kirksville College of Osteopathic Medicine to take me on as a full faculty member to pay my insurance, I can't afford it, they can't afford it.

And when I fill out my licensing questionnaire of have my privileges ever been restricted, I would like to restrict my privileges and not have someone else restrict them.

I also like your idea of unique doctor, but not in a negative connotation. My concerns are what kind of a tail coverage would I pay the JUA that now I could be faced with having to pay with my current insurance carrier if I decide that JUA might meet my interest in a more beneficial fashion? Very concerned about that.

Another interesting comment from some of the insurance companies was that we're not opening the market to new insureds. Well, some days I'm a new insured or first-time client, if you will, and other days I am a mature claims person. Sorry, I mixed my terminologies. But both

are very high-priced tickets. And because I perhaps could not be considered as a newcomer, well, there's no room and the shop is closed, this would put me in the unique JUA.

But my concern is for new and graduating physicians and physicians of the future. If medical students knew this -- and, you know, they have some business acumen, otherwise everybody would have to be related to Mother Teresa to practice -- that they're afraid to take on the job of medicine or I would say the career and the profession of medicine, not the business of medicine.

You know, the business industry hasn't done anything for me, but I've paid the business many, many times in insurance and service and time and, you know, delivering babies and so forth.

So the JUA is -- if that's the alternative to someone who has just finished training -- it took me 10 years to pay my medical school loans. I don't know how long it's going to take a new graduate, plus the cost of bearing the burden of insurance and what's your tail, what do you get and now do you have a label because you're a special doctor who maybe could or couldn't get insurance anywhere else.

Yeah, might be available but not reasonable and not affordable. So I think you need to think past today and you need to think past the issues of insurance and you

need to get past the Scott issue, as you mentioned.

So thanks for your time. I hope to deliver babies some day again before I'm 65.

MR. LAKIN: Are you not delivering now?

DR. TETTAMBEL: I have not been delivering babies for one year. In fact, I'm glad to be here because today is the 25th anniversary of my graduation from medical school.

MR. LAKIN: Congratulations.

DR. TETTAMBEL: Well, maybe; maybe not. I don't know because my rates are going --

MR. LAKIN: You don't have to answer this if you don't want to. Have you been sued?

DR. TETTAMBEL: I have been mentioned in a suit and I have not been sued successfully.

I will say this. The idea of every time you call somebody -- you get a phone call saying, I want records or whatever, I did get a request for records to be sent. I thought, Well, okay, I'll call my company. But the records were not because I was in trouble, but to defend or -- it was for a positive reason, not for a negative reason.

MR. LAKIN: Do you think that in -- as I mentioned, there's sort of -- seems to be niche doctors or doctors in special situations, whether they be, you know, delivering and practicing full-time and teaching, you know,

that kind of thing, that a JUA could be helpful in that regard?

DR. TETTAMBEL: I have to say definitely maybe.

MR. LAKIN: Definitely maybe?

DR. TETTAMBEL: Definitely maybe, for some of the issues I've brought to your attention. That I enjoy teaching and I enjoy practicing, but of course, being a teacher could put you in a compromising situation being responsible for the people under you. So then I would be exacted a penalty because I do teach.

But the companies I've contacted were not very pleased with the fact I was a teacher. And I think if you have teachers or physicians who want to be teachers are now in this special category, teachers don't get paid very much. I know you're going through the school budget thing, I mean, the rest of the legislature, so I don't need more free jobs.

And I would like to be compensated in a fair fashion, but I'd also like to pay fair dues for the right to practice as far as malpractice or buying supplies or even being reimbursed for taking care of an underinsured patient. I hope that answers your question.

I'd like to get back to being, you know, a full-scope obstetrician. I also think the issue of insurance and this niche practices would be the fact that

because I practice in a rural community, I sometimes consider that a niche practice, just because people come from agricultural communities doesn't mean that they can't expect or they don't expect the same type of service or access to technology.

But, you know, you can't afford to have all the technological opportunities in northeast Missouri, southeast Missouri. And St. Louis and Kansas City must be challenged to keep up with the financial opportunities of technology.

But this also brings suits, because I feel that I would like to practice and because I have to have CME and the education plus get experience, but I can't offer this to my patients and they're angry because they want to have it or they saw it on CNN or so forth, so that's another part of the problem of which I think only insurance is -- you know, maybe it's this much -- today it's this much (indicating), but it's bigger than JUA.

MR. LAKIN: I understand. Okay.

Any questions from the panel? If you have a business card or something, could you leave it because we would like to be able to follow-up with you if necessary.

DR. TETTAMBEL: Sure.

MR. LAKIN: Is there anyone else who wants to offer any comments before we move on?

Yes, sir.

DR. TODD: Same thing just to follow-up on what Dr. Tettambel was asking about tail coverage. And I'm David Todd. I'm a family practice doctor from Kirksville and currently with Dr. Tettambel.

But the thing that I have an issue with and I want to ask this in relationship to a JUA is at the present time in Missouri about the only thing that we can buy is claims-made.

For us as physicians with claims-made, we have no way to calculate our risk. Just because we paid $25,000 for this year's coverage, then we have no assurance of what we can get tail coverage for. So we really don't know how much we're paying for the opportunity to practice this year. Is there an opportunity to move back towards occurrence policies?

MR. JONES: I was going to say I think the industry -- we cannot make the industry write occurrence policies as they once did, but the JUA is, by law, required to provide occurrence coverage, if that answers your question.

DR. TODD: It does. Thank you.

MR. LAKIN: All right. Anyone else?

If not, I'll adjourn the hearing. I want to thank you all of you for coming today. Thank you.

C E R T I F I C A T E

STATE OF MISSOURI)
) ss.
COUNTY OF BOONE)

I, Tracy L. Cave, CSR, CCR, with the firm of Associated Court Reporters, and Notary Public within and for the State of Missouri, do hereby certify that I was personally present at the proceedings had in the above-entitled cause at the time and place set forth in the caption sheet thereof; that I then and there took down in Stenotype the proceedings had; and that the foregoing is a full, true and correct transcript of such Stenotype notes so made at such time and place.

Given at my office in the City of Columbia, County of Boone, State of Missouri, this 13th day of July, 2003.

My commission expires December 16, 2005.

_____
TRACY L. CAVE
Notary Public, State of Missouri
(Commissioned in Boone County.)